MississippiCAN Program Frequently Asked Questions

The purpose of this document is to respond to questions from providers, beneficiaries and other interested stakeholders. If you have a question please submit it to MississippiCAN@medicaid.state.ms.us. We will update this document weekly.

1. Will Coordinated Care Organizations (CCOs) have lower reimbursement rates for pediatrics?
   Response: CCOs cannot reimburse any providers at a rate lower than the Medicaid fee-for-service rate.

2. What if a beneficiary is receiving care from a provider who does not participate in any of the plans?
   Response: The beneficiary will need to select a new provider, if their provider did not enroll in any one of the plans.

3. Will risk adjustments be utilized for high risk beneficiaries in the plans?
   Response: All beneficiaries in the plans are considered high risk. However, DOM will develop an arrangement to share risk with the CCOs for NICU babies.

4. Will beneficiaries be able to have services rendered if an out of network specialist services are required to treat the conditions determined through primary provider?
   Response: CCOs will be required to recruit a provider network that includes all types of Medicaid providers and the full range of medical specialties necessary to provide the covered benefits, including contracts with out-of-state providers for medically necessary services.

5. Will there be exceptions to the plans if the specialized services are not available?
   Response: Various "for cause" reasons for disenrollment will be allowed as described in federal requirements, such as: providers that do not (for religious or moral reasons) offer needed services; not all related services are available in the plan's network; or the plan lacks providers experienced in dealing with the enrollee's health care needs.

6. Will providers be able to render services to patients who are not Medicaid beneficiaries?
   Response: Yes.

7. Will providers be able to contract with more than one CCO?
   Response: Yes.

8. Will beneficiaries have Freedom of Choice in determining the best plan for their needs?
   Response: Yes.

9. How will it be ensured that people, who are blind, have low literacy, or limited English proficiency obtained the information to make a choice of a plan?

   Response: Enrollment information/materials will be developed to ensure all people including those with special needs are fully informed of their choice of plan.

10. What is the definition the Division of Medicaid has for high cost beneficiaries and what is considered to be the cost or utilization threshold?

    Response: Targeted, high cost Medicaid beneficiaries are defined as those individuals in a category of eligibility that has been as determined by claims review to have an above average per member per month cost and more than 1,200 member months on an annual basis in the category.

11. Will prescription drugs be part of the benefits offered by the CCOs?

    Response: Yes.

12. Will there be an enrollment transition for the targeted population under MississippiCAN?

    Response: Yes.

13. Will there be grievance and appeal standards implemented in the proposal?

    Response: Yes.

14. Can the provider choose to join a network or by employment to an entity be automatically under the plan?

    Response: A provider may choose to join a network. If the provider is an employee of a network provider and is not reimbursed separately then that provider is also enrolled in the network.

15. How will MississippiCAN ensure an adequate provider network?

    Response: Access standards for the provider network will require the CCOs to insure that for primary care services members travel no more than 60 minutes or 60 miles in the rural regions and 30 minutes or 30 miles in the urban regions.

16. What incentives will providers have that they can serve the targeted population at capitated rates and stay in business?

    Response: Refer to #1.

17. If not all providers participate what guarantee does Medicaid beneficiaries and the public have that providers will be available within a reasonable traveling distance, especially for pregnant women and infants?

    Response: Refer to #19.

18. Will there be quality standards for quality care?

    Response: Yes.

19. Will provider have to cut back on visits in response to low reimbursement rates?
    Response: CCOs cannot reimburse any providers at a rate lower than the Medicaid fee-for-service rate.

20. Why is Mississippi Medicaid beginning the process by targeting such high risk populations?
    Response: We believe this group will benefit most from a care management approach to connect beneficiaries with a medical home and improve use of primary and preventative care services.

21. What consumer protections are being included in this program?
    Response: Members' rights and protections will be required, including the right to:
    - receive needed information about the program;
    - be treated with respect, dignity and privacy;
    - receive information on available treatment options; participate in health care decisions;
    - request copies of medical records; and
    - be furnished services with an adequate delivery network, timely access, coordination and continuity of care, and other specified standards.

    Members' protections will also be provided through access standards, care coordination requirements, quality management programs, and detailed grievance and appeals procedures.

22. How will the CCOs recruit providers to be included in the network?
    Response: The CCOs are responsible for recruitment.

23. How will MississippiCAN program effect reimbursement?
    Response: The CCOs may not reimburse providers at a rate less than Medicaid reimburses.

24. Who will handle the certification for newborn services?
    Response: Each CCO will determine who handles the certification for all services.

25. What changes will occur with the process of obtaining newborn Medicaid ID numbers?
    Response: The process of obtaining newborn Medicaid ID numbers will not change.

26. How can providers participate in this program? If you are already a MS Medicaid provider, does that automatically enroll the provider in the MississippiCAN program?
    Response: To participate in the MississippiCAN program, you must join the provider network of one or more of the CCOs who will soon be providing services to specific groups of beneficiaries. Joining the network of one or more CCOs will be an addition to your relationship as a Medicaid provider, not a substitute for it. The CCOs who are interested in

the MississippiCAN program are now doing preliminary work to develop provider network rosters. The decision to join, how many to join and which to join is left up to the individual provider.

27. Will there be stricter standard for OB patients as far as the timeframe described?
    Response: No. After the CCOs are appointed, all beneficiaries in the specified coverage groups included will receive a package of information from the Division of Medicaid regarding each of the CCOs. Each beneficiary should study the material and decide which CCO will best suit his/her needs. The beneficiary should then mark the enrollment form included in the package and return it to Medicaid. If Medicaid has not received a beneficiary's enrollment form within fourteen (14) days, the beneficiary will be assigned to one of the CCOs. The process and timeline will be the same for each beneficiary.

28. Will there be any standardization in terms of processes, forms, etc. from one CCO to another?
    Response: There will be standardization in areas that are set by Federal mandate. For example, electronic billing will be submitted via ANSI X12 format regardless of the CCO the inpatient beneficiary selected. However, the prior authorization forms and process for that hospitalization could vary from one CCO to another.

29. Will there be a requirement for CCOs to have to meet together at some point to try to standardize provider information, forms, education, processes, etc.?
    Response: DOM will work with the selected CCOs to determine which forms may be standardized. Each appointed CCO is an independent contractor that must meet all the Federal/State guidelines and requirements that the Division of Medicaid currently meets. CCOs will probably have some variation in how they accomplish that task; DOM will not dictate how they do that as long as all guidelines and requirements are completed. For example, different CCOs may choose to handle prior authorizations differently, but all will require some kind of prior authorization.

30. Will these new CCO's have vision and dental benefits for members under their plans?
    Response: The CCOs will be required to offer beneficiaries at least the same covered services and service limits as beneficiaries receive in regular Medicaid. However, the CCOs, at their discretion, may offer additional benefits or expanded service limits.

31. Will this program replace the patient's Mississippi Medicaid?
    Response: The MississippiCAN program is a part of the Mississippi Medicaid program and will be used by the identified Medicaid beneficiaries for all their Medicaid services.

32. Will the patients have to choose between traditional Medicaid and the MississippiCan program?
    Response: Because this is a mandatory program for all beneficiaries in the specified coverage groups, beneficiaries determined to be Medicaid eligible for MississippiCAN will be required to enroll in a CCO.

33. Will the patient be responsible for copays and will this be listed on their card?
    Response: There will be no copayments for MississippiCAN members.

34. Do physicians have to join a "network" to participate or can they choose to accept for specific patients?
    Response: Providers who do not join a CCO network may continue to accept Medicaid as usual for Medicaid patients not enrolled in MississippiCAN. Providers who do not join a CCO network will need authorization from member's CCO for payment of services.

35. Is this plan similar to the Medicare PFFS or Medicare Advantage Plans, by giving the patients a choice of which plan they want to be enrolled in?
    Response: Yes, beneficiaries who must enroll in a CCO will have a choice as to which CCO plan they select for enrollment. Under certain circumstances and at certain times, beneficiaries may change that selection.

36. I have already received contracts from companies asking that we sign a letter of intent to participate with their plan. Should we wait?
    Response: The Division of Medicaid is aware that CCOs are in the process of doing preliminary work to develop provider networks for the MississippiCAN program. Although the Division of Medicaid will not advise on any decision in this regard, we do recommend that providers gather the information and consider participation as soon as possible.

37. Will there be any in-service training on these plans, explaining to both providers and beneficiaries exactly what these plans are and how they will work?
    Response: After selection of the CCOs for participation in the program, each CCO will have its representatives actively recruiting providers to participate in its network. At that time, information will be available from each CCO so that all providers can decide if and how they want to participate. DOM assumes the responsibility of informing affected beneficiaries about options and services.

38. Will this be a referral base to where we have to send records, and keep up with tons of extra information on who referred patients to us, etc.?
    Response: Each CCO will have its own medical record documentation requirements, but there will be significant similarities. Federal and state regulations regarding medical necessity and coordination of care dictate the basic specifics of information exchange and retention.

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